

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005729</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/31/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>CROWNPOINTE OF INDIANAPOLIS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7365 E 16TH ST</b> <b>INDIANAPOLIS, IN 46219</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00177974.</p> <p>Complaint IN00177974- Unsubstantiated due to lack of evidence.</p> <p>Survey Dates: July 31, 2015</p> <p>Facility number: 005729 Provider number: 005729 AIM number: NA</p> <p>Census bed type: Residential: 52 Total: 52</p> <p>Census payor type: Medicaid: 51 Other: 1 Total: 52</p> <p>Sample: NA</p> <p>Crownpointe of Indianapolis was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00177974.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE